

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

#10315

DOB
12/05/1981
CVL-11578873



مركز الرعاية الصحية
RUSAYL HEALTH CENTRE
SAHARA - PAC / RS - PAC

INITIAL EXAMINATION REPORT

| | | | |
|----------------------------|-------------------|-----------------------|-------------------------|
| Place of examination | Date 09 / 04 / 19 | Surname | SALEM HASSAN AL DALUSHI |
| RS PAC CLINIC SAHARA - PAC | | Forenames | SAMT |
| | | Address | TRUCKMAN |
| | | Home Telephone number | 99134888 |

If a dependant or fancee entr employees name jere :-

| | |
|-----------|------------|
| Surname : | Forenames: |
|-----------|------------|

| | | | | | |
|--|---|---|--|----------------------------------|-------------------------|
| Nationality | OMANI | Country of birth | OMAN | Religion | ISLAM |
| <input checked="" type="checkbox"/> Male | <input checked="" type="checkbox"/> Single | <input type="checkbox"/> Widow(er) | Relationship to employee | | Number of Children 2 |
| <input type="checkbox"/> Female | <input checked="" type="checkbox"/> Married | <input type="checkbox"/> Divorced Separated | <input checked="" type="checkbox"/> Wife | <input type="checkbox"/> Son | |
| | | | <input type="checkbox"/> Daughter | <input type="checkbox"/> Fiancee | |

| | | | |
|------------------------|--|--------|------------|
| Reason for examination | <input checked="" type="checkbox"/> Pre-employment | Job :- | SUPERVISOR |
| | <input type="checkbox"/> Pre-overseas | Area:- | BAHJA |

| | |
|-----------------------------------|-----------------------|
| Name and address of family doctor | List your last 3 jobs |
| | (1) |
| | (2) |
| | (3) |



| | | | |
|--|--------------------------|--|--------------------------|
| Are you Registered Disabled Person? (UK) | <input type="checkbox"/> | Do you belong to any Medical Insurance Scheme? | <input type="checkbox"/> |
|--|--------------------------|--|--------------------------|

DO YOU HAVE OR HAVE YOU HAD :- (Tick 'yes' or 'No' column or put a (?) If uncertain exclude minor ailmenis.)

| | Y | N | | Y | N | | Y | N |
|-----------------------------------|---|-------------------------------------|--|---|-------------------------------------|--|---|-------------------------------------|
| 1. Sirius rouble | | <input checked="" type="checkbox"/> | 22. Heart Disease | | <input checked="" type="checkbox"/> | 42. Awarded benifities for Industrial injury/illness | | <input checked="" type="checkbox"/> |
| 2. Neck swellings/flands | | <input checked="" type="checkbox"/> | 23. Rheumatic Fever | | <input checked="" type="checkbox"/> | 43. Treated for a mental condition. eg . depression | | <input checked="" type="checkbox"/> |
| 3. Difficulty in vision | | <input checked="" type="checkbox"/> | 24. Abnormal heartbeat | | <input checked="" type="checkbox"/> | 44. Treated for problem drinking or drug abuse | | <input checked="" type="checkbox"/> |
| 4. Any ear discharge | | <input checked="" type="checkbox"/> | 25. High blood pressure | | <input checked="" type="checkbox"/> | 45. Exposed to toxic substance or noise | | <input checked="" type="checkbox"/> |
| 5. Asthma/bronchitis | | <input checked="" type="checkbox"/> | 26. Stroke | | <input checked="" type="checkbox"/> | FOR WOMEN ONLY | | |
| 6. Hayfever/other allergy | | <input checked="" type="checkbox"/> | 27. Serious chest pain | | <input checked="" type="checkbox"/> | Have you aver had:- | | |
| 7. Any skin trouble | | <input checked="" type="checkbox"/> | 28. Any blood disease | | <input checked="" type="checkbox"/> | 46. An abnormal smear | | |
| 8. Tuberculosis | | <input checked="" type="checkbox"/> | 29. Kidney disease | | <input checked="" type="checkbox"/> | 47. Any gynaecological treatment | | |
| 9. Shortness of breath | | <input checked="" type="checkbox"/> | 30. Painful passage of urine | | <input checked="" type="checkbox"/> | 48. Are you pregnant? | | |
| 10. Coughed/vomited blood | | <input checked="" type="checkbox"/> | 31. Blood in urine | | <input checked="" type="checkbox"/> | 49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE ? | | |
| 11. Severe abdominal pain | | <input checked="" type="checkbox"/> | 32. Diabetes | | <input checked="" type="checkbox"/> | | | |
| 12. Stomach ulcer | | <input checked="" type="checkbox"/> | 33. Headaches /migraine | | <input checked="" type="checkbox"/> | | | |
| 13. Recurrent indigestion | | <input checked="" type="checkbox"/> | 34. Dizziness/tainting | | <input checked="" type="checkbox"/> | | | |
| 14. Jaundice or hepatitis | | <input checked="" type="checkbox"/> | 35. Epilepsy | | <input checked="" type="checkbox"/> | | | |
| 15. Gall bladder disease | | <input checked="" type="checkbox"/> | 36. Joints/spinal trouble | | <input checked="" type="checkbox"/> | | | |
| 16. Marked change in bowel habits | | <input checked="" type="checkbox"/> | 37. Surgical operation | | <input checked="" type="checkbox"/> | | | |
| 17. Blood in stools (motions) | | <input checked="" type="checkbox"/> | 38. Serious accident /tracture | | <input checked="" type="checkbox"/> | | | |
| 18. Marked change in weight | | <input checked="" type="checkbox"/> | 39. Tropical disease | | <input checked="" type="checkbox"/> | | | |
| 19. Varicose veins | | <input checked="" type="checkbox"/> | 40. Fear of heights | | <input checked="" type="checkbox"/> | | | |
| 20. Lump in breast/armpit | | <input checked="" type="checkbox"/> | HAVE YOU EVER BEEN:- | | | | | |
| 21. Cancer | | <input checked="" type="checkbox"/> | 41. Rejected for employment or insurance for medical reasons | | <input checked="" type="checkbox"/> | | | |

| | | | |
|-----------------------------|------------|---------------------------------|--|
| How much tabacco each day ? | Non-smoker | Average daily alcohol consupion | |
|-----------------------------|------------|---------------------------------|--|


| | | | | | | | | | | |
|----------------|---------------|-------------------------------------|---------------------|-------------------------------------|----------|-------------------------------------|---------|-------------------------------------|---------------|-------------------------------------|
| Family history | Diabetes | <input checked="" type="checkbox"/> | Tuberculosis | <input checked="" type="checkbox"/> | Epilepsy | <input checked="" type="checkbox"/> | Asthama | <input checked="" type="checkbox"/> | Eczerna | <input checked="" type="checkbox"/> |
| | Heart disease | <input checked="" type="checkbox"/> | High blood pressure | <input checked="" type="checkbox"/> | Stroke | <input checked="" type="checkbox"/> | Cancer | <input checked="" type="checkbox"/> | Blood disease | <input checked="" type="checkbox"/> |

PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT :-

I declare these statements to be true to the best of my knowledge and belief and I agree that the result of this medical in general terms may be revealed to the company if required, and the details sent to my own doctor if this is considered necessary by the examining medical officer.

| | | | |
|------|----------|------------------------|--|
| Date | 09.04.19 | Signature of applicant | |
|------|----------|------------------------|--|

FOR COMPLETION BY EXAMINING DOCTOR OR SISTER
FURTHER DETAILS OF MEDICAL HISTORY AND RECREATIONAL ACTIVITIES

| N - Normal A - Abnormal Please Describe | | PHYSICAL EXAMINATION | | | | | | | | | | | |
|---|---|--|--------------|--------------|--------|--------------|--------------|------------------------|--------------|--------------------------|------------------|----------------|------------------|
| N | A | <p>BMI - 27.2 kg/m² HR - 76 bpm</p>  | | | | | | | | | | | |
| ✓ | | | | | | | | | | 1. Eyes & Pupils | | | |
| ✓ | | | | | | | | | | 2. E.N.T. | | | |
| ✓ | | | | | | | | | | 3. Teeth & Mouth | | | |
| ✓ | | | | | | | | | | 4. Lungs & Chest | | | |
| ✓ | | | | | | | | | | 5. Cardiovascular System | | | |
| ✓ | | | | | | | | | | 6. Abdo. Viscera | | | |
| ✓ | | | | | | | | | | 7. Hernial Orifices | | | |
| ✓ | | | | | | | | | | 8. Anus & Rectum | | | |
| ✓ | | | | | | | | | | 9. Genito - urinary | | | |
| ✓ | | | | | | | | | | 10. Extremities | | | |
| ✓ | | | | | | | | | | 11. Muscula-skeletal | | | |
| ✓ | | | | | | | | | | 12. Skin & Varicose Vns. | | | |
| ✓ | | | | | | | | | | 13. C.N.S. | | | |
| ✓ | | | | | | | | | | 14. Breasts | | | |
| | | 15. | HEIGHT cm | WEIGHT kg | B.P. | HEARING L | HEARING R | VISION: Uncorrected | DISTANT R | NEAR R | COLOUR VISION | BLOOD GROUP | |
| | | | 184 | 92.0 | 131/85 | | | | | | | | |
| N | A | LABORATORY AND SPECIAL INVESTIGATIONS | | | | | | | | N | A | | |
| ✓ | | 1. Urinalysis | | | | | | | | | | | 6. Audiogram |
| ✓ | | 2. Hb Bloodcount ESR | | | | | | | | | | | 7. Lung Function |
| ✓ | | 3. Sarum Profile | | | | | | | | | | | 8. Chest X-Ray |
| | | 4. Stool | | | | | | | | | | | 9. Drug Screen |
| | | 5. E.C.G. | | | | | | | | | | | 10. CR Screen |

BMI - 27.2 kg/m² OTHER FINDINGS (physique, scars, disabilities, mental stability etc.)

ASSESSMENT

☒ FIT ALL AREAS ☐ FIT HOME SERVICES ONLY ☐ UNFIT/UNSUITABLE ☐ MAY BE REASSESSED

Date 10.04.19

Signature

MD HASAN MANOUB KHAN BAYZID
MEDICAL OFFICER
RUSAYL HEALTH CENTRE
MOH LIC NO. 15694

Doctor / Sister

REVIEW/CONSULTATION

Date

Signature

Name (Block Capitals)

Doctor / Sister